- Measures have been taken, by the Utah Department of Health, Bureau of Health Promotions, to ensure no conflict of interest in this activity.
- CNE/CEU's are available for this live webinar. You must take the pre and post tests. 80% is required on the post test to receive CNE/CEU's.
- Certificates will be emailed out to you within two weeks

The Patient Protection And Affordable Care Act

Affordable Care Act, RDs & CDEs: Learn the Language and Laws and Leap Into the Land of Health Care Reform!

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Mary Ann Hodorowicz Consulting, LLC April 2015

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Learning Objectives

1. Name the 3 goals of ACA called ‘Triple Aim”.
2. Describe current healthcare insurance issues that the ACA aims to decrease or eliminate.
3. Describe how the ACA aims to improve the healthcare system of America.
4. State the domains within the ACA which DEs/RDs will have key roles and responsibilities.
5. Summarize the preventive services for adults and children that insurers must cover that are relevant to DE/RD practice.
6. Describe two new models of healthcare delivery that have been implemented under the ACA

Learning Objectives, Continued

7. Summarize the steps in the ACA Action Plan that help DEs/RDs align themselves with the new roles and responsibilities under the ACA.

8. Describe the major components of a DSMES/MNT Program business plan.

9. Identify the component of the business plan where DEs/RDs show their value within the PCMH and ACO.

10. State strategies DEs/RDs can utilize to successfully assume new roles and responsibilities under the ACA.

Topic Outline of Presentation

1. Key Goals of PPACA and Healthcare Reform: **TRIPLE AIM**
2. Affordable Care Act: Main Initiatives = **10 Titles**
3. What ACA Wants to DECREASE….17 Things:
   D.O.G. C.H.A.I.N.S.
4. What ACA Wants to INCREASE…..32 Things:
   Q.U.E.E.N.S. S.H.O.P.
5. Four Areas of ACA Within Which DE's and RDs Will Have Key **Roles and Responsibilities** (R/R's)
6. Benefits of ACA to Providers and Patients Spell
   P.R.E.M.I.E.R.

7. Review of Key Points of Each Part of P.R.E.M.I.E.R. Relevant to DEs/RDs

8. Changing Roles and Responsibilities (R/R's) of DEs/RDs

9. Strategies for DEs/RDs to Assume New R/R's and to Apply Mandates of ACA

10. List of 12 Major Components of DSMES/MNT Program Business Plan

11. The 10 Step Action Plan to Align You and Your Career with New R/R's that ACA Requires and to Apply its Mandates

LEGEND

- ACO = Accountable Care Organization
- CMS = Centers for Medicare and Medicaid Services
- DEs = Diabetes Educators
- Demonstration Projects = DPs
- DHHS = Dept. of Health and Human Services
- DSMES = Diabetes Self-Management Education & Support
- FFS = Fee for Service
- FTE= Full Time Equivalent
- HES = Health Education Specialist
- HCPr = Health Care Provider
- HIT = Health Information Technology
- HCP = Health Care Professional
- HCPSA = Health Care Professional Shortage Area
- MPFS = Medicare Physician Fee Schedule
- PCMH = Patient Centered Medical Home
- PPACA = Patient Protection and Affordable Care Act
- PQRI = Physicians Quality Reporting Incentive
- r/t = related to
- R/R's = Roles and Responsibilities
- USPSTF = United States Preventive Services Task Force

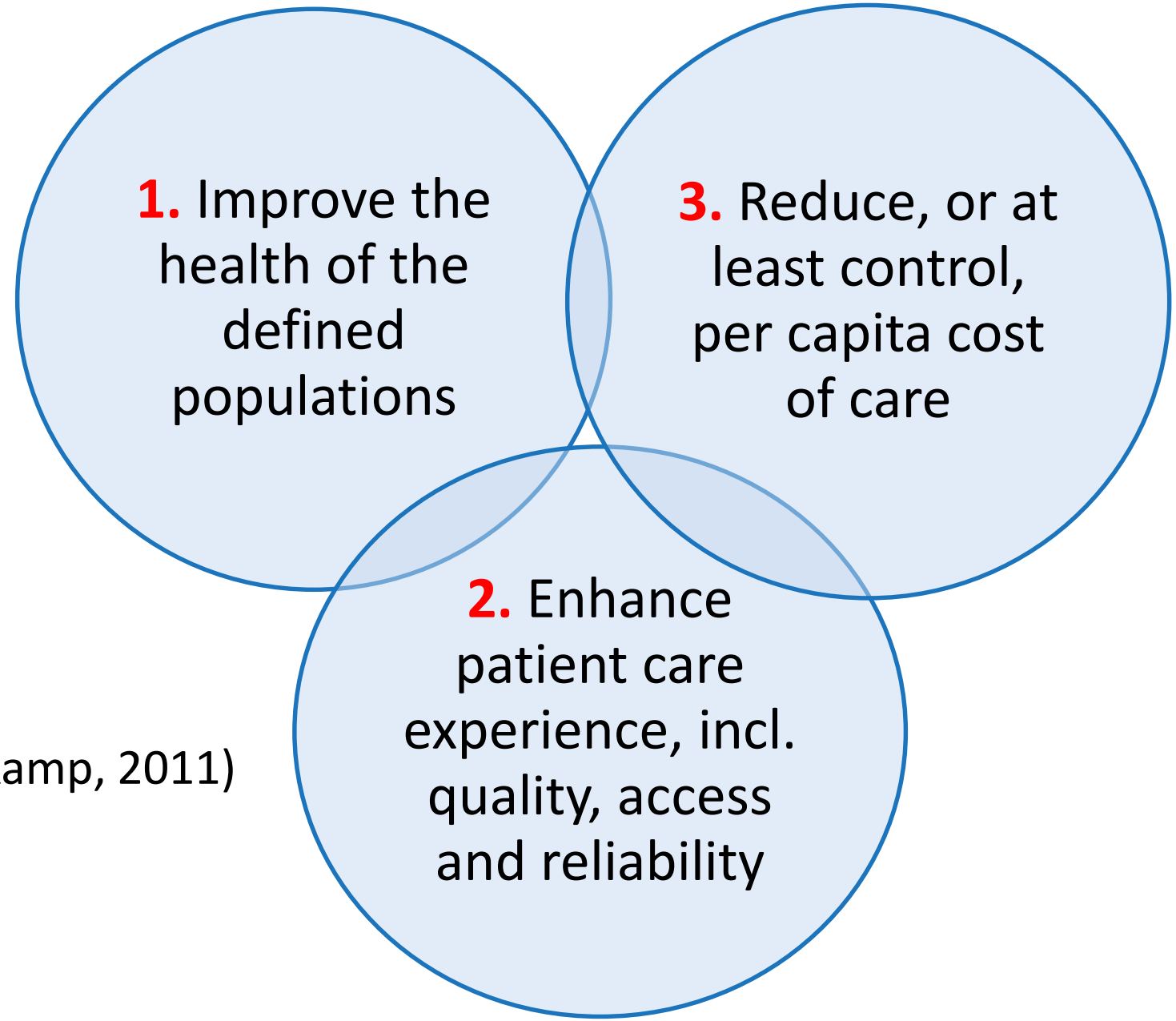
PPACA is almost 1000 pages long!

For RDs, **PPACA** *really* stands for:

Positions and Pathways for

Additional Career Avenues!

Key Goals of PPACA and Health Care Reform: TRIPLE AIM



(Rehkamp, 2011)

Key Goal of PPACA and Health Care Reform: TRIPLE AIM

1. **Improve the health of the defined populations via:**
   - ↑ vaccination rates
   - Prevention and wellness programs
   - Lowering obesity rates
   - Improving primary care

(Rehkamp, 2011)

Key Goals of PPACA and Health Care Reform: TRIPLE AIM

2. Enhance patient care experience, quality, access, reliability

- 5 key **quality** domains
  - Patient experience of care
  - Care coordination
  - Patient safety
  - Preventive health
  - At-risk population and frail elderly health

(Rehkamp, 2011)

Key Goals of PPACA and Health Care Reform: TRIPLE AIM

3. Reduce, or at least control, per capita cost of care

- New payment methodologies designed to incent providers to manage care better, at lower cost

(Rehkamp, 2011)

Affordable Care Act: Main Initiatives -- 10 Titles

Increase Health Care Coverage

- **Title I**: Affordable Health Care – Private Coverage Expansion

- **Title II**: Public Programs – Medicaid, SCHIP, DSH, Rx Coverage

Increase Quality and Efficiency and Decrease Costs

- **Title III**: Improving Quality and Efficiency of Health Care

Affordable Care Act: Main Initiatives -- 10 Titles

- **Title IV:** Prevention of Chronic Disease and Improving Public Health
- **Title V**: Health Care Workforce
- **Title VI:** Transparency and Program Integrity
- **Title VII:** Improving Access to Innovative Medical Therapies

Affordable Care Act: Main Initiatives -- 10 Titles

Raise More Revenue

- **Title VIII**: Community Living Assistance Services and Supports

- **Title IX**: Revenues Provisions – Excise Tax on High-Cost Insurance Plans

- **Title X:** Changes and Additions to Preceding 9 Titles

You got into the healthcare profession to serve patients….

ACA protections are designed to help you ***KEEP*** serving them!

What ACA Wants to DECREASE:

17 Things

= D.O.G. C.H.A.I.N.S.

D	**D**enial of coverage by insurer: • For mistakes on application or claims • After coverage implemented • For pre-existing conditions • When attempting to get new coverage **D**iscrimination, fraud and abuse by insurers
O	**O**besity rates **O**vertreatment **O**verpayment to providers **O**verpayment by Medicare to: • Sub-specialists • Hospitals • Home health
G	**G**randfathered (old) health plans over next 5 years

C	**C**hronic diseases (new diagnoses and exacerbation of) **C**ost of insurance and coverage by patient: • Co-pays • Premiums • Deductibles
H	**H**ealthcare costs **H**ealthcare providers working in silos resulting in ↓ quality
A	**A**dmissions (inpatient, ER, LTC, etc.) **A**buses and fraud by providers in billing for services
I	**I**nsurers capping payments after ceiling reached by patient
N	**N**on-insured and underinsured
S	**S**ingle fee-for-service payments to providers **S**taggering administrative complexities and paperwork

What ACA Wants to INCREASE:

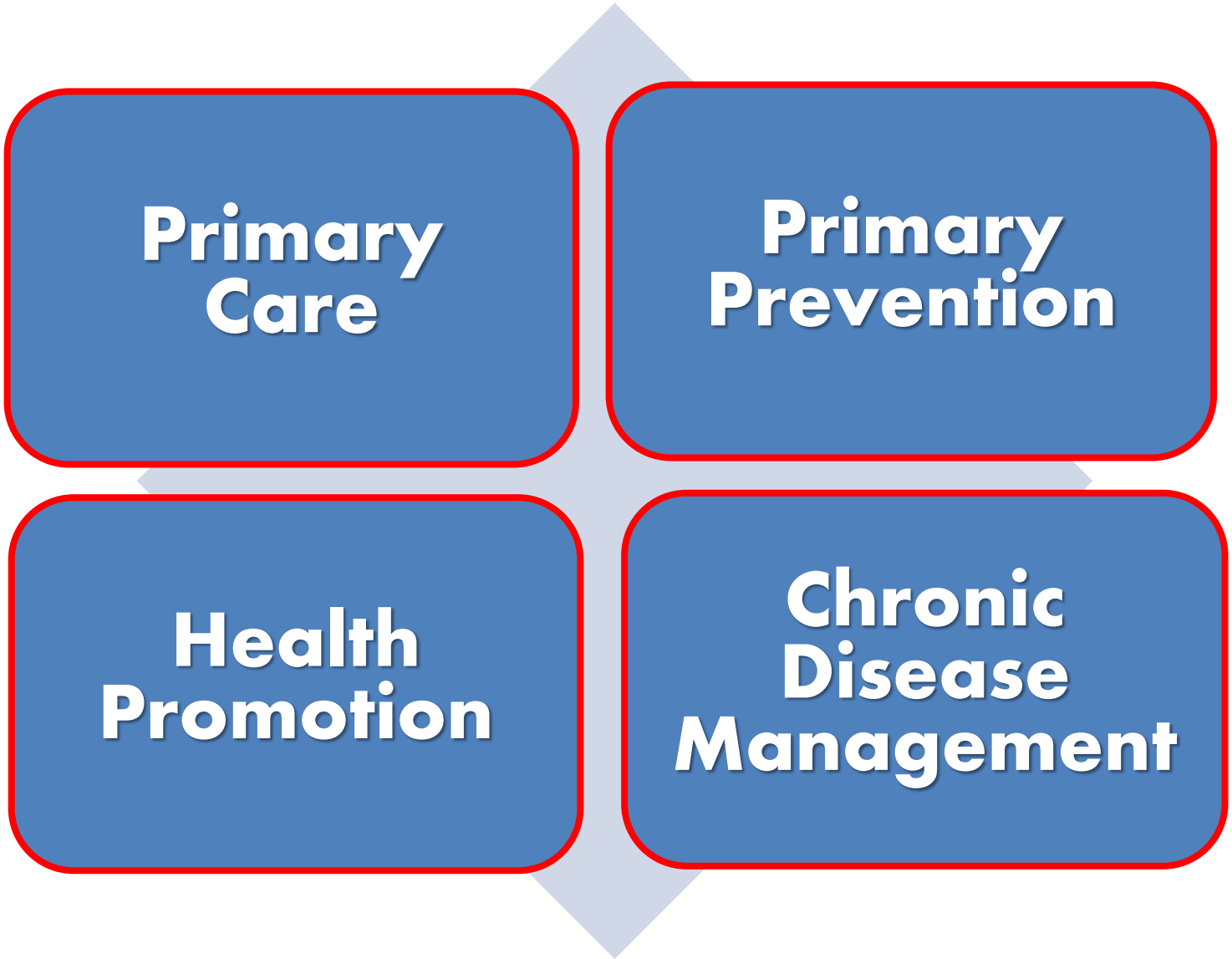
32 Things

= Q.U.E.E.N.S. S.H.O.P.

Q	**Q**uality of care
U	**U**ser-friendly comparative health plan shopping
E	**E**fficiencies across entire health system **E**fficient, NEW models of care delivery: Patient Centered Medical Homes, Accountable Care Organizations, schools
E	**E**xpanded variety of health plans at different price points **E**ngaged multi-disciplinary health care teams **E**ssential health benefits that all insurers must cover **E**ffective care coordination, integration + transitional care **E**ffective payment models: bundled, capitated, incentive and ↓ pay if key improvements not made
N	**N**on-traditional care (telehealth, phone, online, email)
S	**S**afe care **S**creenings for prevention, disease, identifying risk factors

S	**S**elf-management pt education; **S**elf-management by pts
H	**H**ealth promotion and wellness (especially at work sites) **H**ealth benefits (especially preventive) **H**ealth information technology including EMRs/EHRs
O	**O**utcomes….across entire spectrum!
P	**P**ay for quality, **P**ay for performance, **P**ay for reporting (value!) **P**opulation management **P**atient experience **P**atient engagement **P**atient centered care **P**rimary care prevention **P**rimary care providers **P**rimary care practices **P**rimary care and **P**atient chronic disease management **P**rotection of benefits thru life regardless of diseases **P**reventive services at no cost sharing by patient (free!) **P**remium payment reductions if engaged in health promotion

Four Areas of ACA Within Which Diabetes Educators and RDs Will Have Key Roles and Responsibilities (R/R's)



Benefits of ACA to Providers and Patients Spell **P.R.E.M.I.E.R.**

P = **P**rotection of Patient Coverage

R = **R**eforms in Insurance Marketplace

E = **E**xpansion of Preventive Services, **E**xpansion of Coverage

E = **E**xpansion of Coverage and **E**xchanges

E = **E**xpansion of Primary Care Providers and Workforce

M = **M**odels of New Care Delivery: ACO, PCMH, in Schools

I = **I**nitiatives to Increase Affordability of Coverage

I = **I**nvestments in HIT, Quality, Efficiency, Population Health

E = **E**conomic Incentives + Payment Models to ↑ Quality, Efficiency

R = **R**outing of Federal Grants to States to Foster ACA Goals

P = Protection of Patient Coverage

- ENDS insurance industry excesses and abuses:
  - Healthcare premiums more than doubled in past 10 yrs, while insurance company profits rose
  - Law will prevent:
    - Denial of coverage for pre-existing conditions
    - Cancelled coverage due to mistakes on application
    - Charging women more than men
    - Lifetime benefit limits
    - Annual limits on coverage

R = Reforms in Insurance Marketplace

BEFORE: insurer spent **≥$0.40** of every premium dollar on operations:

- Overhead, marketing, CEO salary

60% on consumer / 40% on operations

NOW, insurers can only spend **≤$0.20** on operations; must spend ≥$0.80 on consumer health care

If not, they must **repay money** to federal government

80% on consumer / 20% on operations

R = Reforms in Insurance Marketplace

San Francisco Chronicle

Anthem withdraws rate increases

Insurance: Big hikes fueled furor, legislation

April 30, 2010 | By Victoria Colliver, Chronicle Staff Writer

Los Angeles Times

Blue Shield cancels insurance rate increase

March 16, 2011 | By Duke Helfand, Los Angeles Times

The New York Times

BUSINESS BRIEFING | HEALTH CARE

Connecticut Rejects Insurance Rate Increase

By THE ASSOCIATED PRESS

Published: December 3, 2010

R = Reforms in Insurance Marketplace

- Creates new rules that standardize and simplify claims and payment processes
  - Fewer phone calls to patients and plans
  - Reduced postage and paperwork costs
- Supports your use of Electronic Medical Records
- Invests in programs designed to help providers transition to:
  - Electronic payments
  - EMRs

E = Expansion of Preventive Services

- ACA **Preventive Services** rated **A** or **B** by United States Preventive Services Task Force (USPSTF) must be covered (plus others not rated) **without cost sharing** by:

  – **MEDICARE:**

    - MNT: T1, T2 diabetes; GDM; pre-dialysis CKD; period of 36 months after kidney transplant
    - Intensive Behavioral Therapy (IBT) for Obesity Benefit
    - Initial Preventive Physical Exam

E = Expansion of Preventive Services

- Initial Annual Wellness Visit (AWV):
  - Eligible providers:
    - MD, DO
    - PA, NP, CNS: qualified non-physician practitioner
    - **RD, nutrition professional, health educator or other licensed practitioner,** or team of such health professionals working under **direct supervision of physician** (i.e., office suite, hospital OP dept., clinic, etc. where physician is available if needed)

E = Expansion of Preventive Services

- Goal:
  - Health promotion
  - Disease detection
  - Fostering coordination of screening
  - Preventive services that may already be covered and paid for under Medicare Part B.

E = Expansion of Preventive Services

- What **initial** and **subsequent years** AWVs include:
  - **Health Care Assessment Screening:**
    - Medical and family hx
    - Providers/suppliers providing medical care
    - Ht, wt, BMI, waist circumference, BP
    - Other measurements as necessary
    - Cognitive impairment assessment
    - Risk factors for depression or other mood disorders using standardized screening tests

E = Expansion of Preventive Services

- Functional ability and level of safety using standardized questionnaires
- Written screening schedule for next 5 to 10 years, based on USPSTF recommendations
- Risk factors and conditions for which primary, secondary, or tertiary interventions recommendations, treatment options and associated risks, benefits

E = Expansion of Preventive Services

- **Personalized Prevention Plan (PPP)**:
  - PPP + referral as needed to health education or preventive counseling services, such as:
    - Community lifestyle programs to ↓ health risks and ↑ self-management & wellness
    - **Nutrition**
    - Weight loss
    - Physical activity
    - Tobacco-use cessation
    - Fall prevention

E = Expansion of Preventive Services

- ACA **Preventive Services** rated **A** or **B** by USPSTF
  - **MEDICAID**
    - As of 1-1-14, new expanded eligibility for enrollment:
      - <65 y/o……. and not pregnant
      - Income <133% of federal poverty level ($14,500 for individual; $29,700 for family of 4 in 2011)
    - Ends very limiting eligibility criteria:
      - Low-income, AND
      - Mental/physical disability

E = Expansion of Preventive Services

- By 1-1-14, states had to choose whether or not to cover **Preventive Services** under Medicaid program
- **IF** agreed to cover:
  - Will receive 100% federal funding for 1st 3 yrs to support expanded coverage, phasing down to ≥90% in subsequent years
- As of 1-1-14:
  - 25 states and DOC expanded Medicaid
  - ~ 803,077 people now deemed eligible for Medicaid or Children's Health Insurance Program

E = Expansion of Preventive Services

- ACA **Preventive Services** rated **A** or **B** by USPSTF that must be covered (+ others not rated) by:
  - **NON-GRANDFATHERED (NEW as of 9-23-10) HEALTH CARE PLANS**

ONLY THOSE RELEVANT TO RDS

AND DIABETES EDUCATORS LISTED

E = Expansion of Preventive Services

- **Screenings:**
  - **T2 diabetes in asymptomatic adults with BP >135/80**
  - **GDM screening** for women 24-28 weeks pregnant and those at high risk of developing GDM
  - Urinary tract/other infection for pregnant women
  - **Iron deficiency anemia in pregnant women**
  - Osteoporosis for women >60 depending on risk factors

WHAT ARE YOUR OPPORTUNITIES?

E = Expansion of Preventive Services

- **Lipid disorders**
- **High BP**
- **Depression**
- Alcohol misuse
- Tobacco use
- **Obesity**

– **Obesity counseling interventions:**

- Clinicians should offer or refer adult pts with BMI >30 to intensive, multi-component behavioral interventions

WHAT ARE YOUR OPPORTUNITIES?

E = Expansion of Preventive Services

- **Intensive dietary behavioral counseling** in ***primary care*** for patients with:
  - Hyperlipidemia
  - Risk factors for CVD
  - Higher risk of chronic disease **(e.g., prediabetes pts)**
  - Diet-related chronic disease

WHAT ARE YOUR OPPORTUNITIES?

E = Expansion of Preventive Services

- **Intensive dietary behavioral counseling** can be delivered:
  - By primary care physicians (PCPs)
  - By qualified non-physician practitioners (NPPs)
  - By referral from above to other specialists, such as:
    - **RDs**
    - **Nutritionists**

WHAT ARE YOUR OPPORTUNITIES?

E = Expansion of Preventive Services

- **Re: Intensive dietary behavioral counseling:**
  - Academy of Nutrition and Dietetics sent official letter to USPSTF to revise language of Draft Recommendation when finalized to:
    - *The U.S. Preventive Services Task Force (USPSTF) recommends offering or referring adults with overweight or obesity who have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions and Medical Nutrition Therapy (delivered by specialists such as a registered dietitian nutritionist or other nutrition professional) to promote a healthy diet and physical activity for CVD prevention.*

E = Expansion of Preventive Services

- **Supplements and other OTC:**
  - Folic acid supplements for women who may become pregnant
  - Aspirin for men age 45-79 and for women age 55-79
- **Behavioral counseling interventions:**
  - Tobacco cessation
  - Alcohol and other substance abuse
  - Pregnancy-tailored counseling for those who smoke
  - Depression support, treatment and follow-up
  - Breastfeeding comprehensive support and counseling

WHAT ARE YOUR OPPORTUNITIES?

E = Expansion of Preventive Services

- **Women's preventive services without copayments or deductibles:**
  - Annual preventive-care medical visits and exams
  - Contraceptives (are exemptions
  - Mammograms
  - Colonoscopies
  - **Blood pressure tests**
  - Childhood immunizations
  - Domestic violence screenings
  - H.I.V. screenings
  - Breast feeding counseling, devices, including breast pumps
  - **Screening for gestational diabetes in pregnant women**
  - DNA tests for HPV as part of cervical cancer screening

E = Expansion of Preventive Services

Preventive Health Services for CHILDREN w/o cost sharing:

– **Screenings:**

- BP
- Depression
- Lipid disorders
- Lead screening for children at risk of exposure
- Hematocrit or hemoglobin
- Height, weight and BMI measurements
- Alcohol and other substance abuse
- Obesity screening in children >6 y/o

WHAT ARE YOUR OPPORTUNITIES?

E = Expansion of Preventive Services

- **Intensive behavioral counseling interventions:**
  - To offer or refer for comprehensive, intensive behavioral counseling for **obese children to promote sustained weight loss**

  - Alcohol and other substance abuse
  - Tobacco cessation in ages 11 - 21 y/o
  - Depression support, treatment and follow-up

WHAT ARE YOUR OPPORTUNITIES?

E = Expansion of Preventive Services

– **Supplements:**

- Iron supplements for children ages 6 to 12 months at risk for anemia

- Oral fluoride supplements for children from age 6 months through 5 years

WHAT ARE YOUR OPPORTUNITIES?

E = Expansion of Preventive Services

- If ACA does **NOT** specify frequency, method, treatment or setting for preventive benefit, then insurer to determine

- Patient cost-sharing rules for A/B rated preventive services:
  - Furnished by **In-Network Providers**:
    - Must be covered *without* patient cost sharing (no copayment, deductible, coinsurance)
  - Furnished by **Out-of-Network Providers**:
    - Cost-sharing requirements may…and usually…..apply

E = Expansion of Preventive Services: Blue Cross of AR Example

PART of
Blue Cross of Arkansas
coverage guidelines
for
SOME of ACA preventive services.

Good example of how each insurer can select own procedure and dx codes for claims.

(Coding guidelines for PPAA preventative benefits plans, Arkansas Blue Cross and Blue Shield website, 2013)

E = Expansion of Preventive Services: Blue Cross of AR Example

Blue Cross of Arkansas Plan Under PPACA to Cover Preventive Services

- ***Nutrition (Dietary) Counseling, Adults***
  - *USPSTF recommends intensive behavioral dietary counseling for adult patients with:*
    - *Hyperlipidemia*
    - *Other known risk factors for cardiovascular*
    - *Diet-related chronic disease.*
      - *Intensive counseling can be delivered by primary care clinicians or by referral to other specialists such as:*
        - *Nutritionists or*
        - *Dieticians (Grade B)*

E = Expansion of Preventive Services: Blue Cross of AR Example

- ***CPT/HCPCS Codes:***
  - *97802 - 97803 – Medical nutrition therapy (not reported by physicians)*
  - *99401 - 99404 – Preventive medicine counseling (15, 30, 45, 65 min)*
    - *99403-99404 require review of records*
  - *G0108 – Diabetes training services*
  - *G0270 – Medical nutrition therapy*
  - *S9140 – Diabetic management program, follow-up visit to non-MD provider*
  - *S9141 – Diabetic management program, follow-up to MD provider*
  - *S9452 – Nutrition classes, non-physician provider, per session*

E = Expansion of Preventive Services: Blue Cross of AR Example

- *S9455-S9465 – Diabetic management*
- *S9470 – Nutritional counseling, dietician visit*

– ***ICD-9 Codes:***

- *V65.3 – Dietary surveillance and counseling*

– ***Frequency:***

- *Allowed up to 8 visits a year if medically necessary*

E = Expansion of Preventive Services: Blue Cross of AR Example

- ***Obesity in Adults, Screening and Counseling USPSTF Recommendation***
  - *USPSTF recommends screening all adults for obesity*
  - *Clinicians should offer or refer patients with BMI of >30 kg/m2 to intensive multicomponent behavioral interventions. (Grade B)*
  - ***CPT/HCPCS Codes:***
    - *99385-99387 – Initial comprehensive preventive medicine E&M of individual*
    - *99395-99397 – Periodic comprehensive preventive medicine re-evaluation & management*

E = Expansion of Preventive Services: Blue Cross of AR Example

- *99401 – Preventive medicine counseling; 15 min*
- *99402 – Preventive medicine counseling; 30 min*
- *99403 – Preventive medicine counseling; 45 min*
- *99404 – Preventive medicine counseling; 60 min*
  - *99403 & 99404 require review of records*
  - *99401–99404 considered components of 99381-99397*

– ***ICD-9 Codes:***

- *V70.0 – General medical exam*
- *V77.8 – Screening for obesity*

– ***Frequency:*** *Allowed up to 12 visits per year*

E = Expansion of Coverage and Exchanges

- "**Individual mandate**":
  - Requires non-exempt **individuals** who do **NOT** receive health insurance through employer or government program to maintain "**minimum essential health insurance coverage**", or *pay tax penalty*
- Can meet mandate via **Health Insurance Exchanges**
  - Minimum coverage = **10 Essential Health Benefits**

E = Expansion of Coverage and Exchanges

- Health Insurance Exchange Marketplace
  - State-specific health plan competitive marketplace for:
    - **Uninsured individuals** (effective 1-1-14) and
    - **Small employers** who will be required to provide health plans for employees (effective 1-1-15)
  - 10-1-13: Transparent "apples to apples" health plan shopping began for **individual health plans**
  - Entities selected to **"qualify"** health plans/exchanges:
    - National Committee on Quality Assurance (NCQA)
    - Utilization Review Accreditation Commission

E = Expansion of Coverage and Exchanges

- **10 Essential Health Benefits (EHBs)** must be covered by
  - Qualified health plans sold to individuals by 1-1-14
  - Small employers by non-grandfathered health plans (= new plans after 9-23-10) by 1-1-15 both inside ***and*** outside of state's exchange market

E = Expansion of Coverage and Exchanges

- **Large employers** who have between 50-99 full-time employees who meet certain criteria (effective 1-1-16)
  - During 2-9 - 12-31-14, cannot ↓ workforce or employee service hrs to have <50 - 99 FTEs
- **Self-insured** employers (2017 date)
  - These employers must report annually to federal government of compliance status
  - Penalties imposed when:
    - FT employees not provided with minimum EHBs
    - Employer's plan is not affordable
    - Employer fails to provide minimum value plan

E = Expansion of Coverage and Exchanges

- *"If you have insurance that you like, then you will be able to keep that insurance."*.....Barack Obama
  - **Beginning in 2014**: insurers dropped millions from noncompliant plans
  - Result: Obama enacted policy allowing insurers to **extend** existing noncompliant plans up to **Oct. 2014**
- Plans renewed after **Oct. 1, 2014** have to:
  - Be a plan originally "grandfathered in" back in 2010, or
  - Must meet ACA coverage standards

E = Expansion of Coverage and Exchanges

- **EHBs** must include **10 broad** services (insurer further defines):
  - **Ambulatory patient services**
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health & substance use services and behavioral health tx
  - Prescription drugs
  - Rehabilitative and habilitative* services and devices
  - Laboratory services
  - **Preventive & wellness services and chronic disease management**
  - Pediatric services, including oral and vision care

*Habilitative services defined as "health care services that help a person keep, learn or improve skills and functioning for daily living."

E = Expansion of Coverage and Exchanges

- Most relevant of 10 EHBs for **diabetes educators and RDs**:
  - **Ambulatory Patient Services**
  - **Preventive and Wellness Services and Chronic Disease Management**

WHAT ARE YOUR OPPORTUNITIES?

E = Expansion of Coverage and Exchanges

- Exchanges administered by state or federal government or both
- Sliding scale tax credits and subsidies to individuals who qualify to offset premium, deductible, co-pay, per income levels
  - Silver plan is lowest to purchase to qualify
- 5 different "levels" of *individual* and *small group* **"qualified health plans"** (QHPs)…aka, **"exchanges"**

E = Expansion of Coverage and Exchanges

- 4 "metal" levels of qualified health plans:
  - ↑ metal = ↑ premium, ↓ deductible, co-payments

    - **Bronze** plan:

      - Lowest premium in exchange for highest out-of-pocket costs (copayments, deductibles)
      - Insurer pay: 60% Patient pay: 40%

E = Expansion of Coverage and Exchanges

- **Silver** plan:
  - Lowest level to be eligible for federal subsidy to offset premiums, copays, deductibles
  - Insurer pay: 70% Patient pay: 30%
- **Gold** plan:
  - *Higher* premiums in exchange for *lower* deductible, co-payments
  - Insurer pay: 80% Patient pay: 20%

E = Expansion of Coverage and Exchanges

- **Platinum** plan:
  - *Highest* premiums in exchange for *lower* deductible, co-payments
  - Insurer pay: 90% Patient pay: 10%

E = Expansion of Coverage and Exchanges

- **Catastrophic** plan (5th type):
  - For people <30 or families before plan year begins,

    OR

  - Exempt from individual insurance mandate due to financial hardship (cost of **bronze plan** coverage **>8%** of annual household income)

  - 10 EHBs covered after person pays cost sharing equal to maximum out-of-pocket limits

I = Increase Affordability of and Access to Coverage

- **Wellness/prevention for employees**:
  - Permits employers to offer employees insurance-based rewards for participating in **wellness programs** and meeting certain **health-related standards**:
    - Insurance premium discounts
    - Waivers of cost-sharing requirements
    - Other insurance benefits

WHAT ARE YOUR OPPORTUNITIES?

I = Increase Affordability of and Access to Coverage

- **School-based health centers (SBHCs)**
  - ACA funding SBHC sites in medically underserved areas
  - Expand **preventive** + **primary health care** at existing sites

- SBHCs provide:
  - Primary care (focus on prevention and early intervention)
  - **Health education and health promotion**
  - **Nutrition education**
  - Mental health care
  - Substance abuse counseling
  - **Case management**
  - Dental health

WHAT ARE YOUR OPPORTUNITIES?

E = Expansion of Primary Care Providers & Workforce

100 studies show urgent need to prevent shortages of **PCPs and** critical evidence of **primary care** to:

- ↑ outcomes
- ↓ cost of care

(Starfield et al, *Health Aff (Millwood)*, 2005)

Primary care delivers better health outcomes at ↓ cost:

↓ medication use
↓ morbidity
↓ mortality
↓ expenditures
↑ patient satisfaction
↑ equity in health care

(Starfield et al, *Health Aff (Millwood)*, 2005; American College of Physicians, 2008)

E = Expansion of Primary Care Providers & Workforce

- **Primary care** setting defined by CMS:
  - *"One in which there is provision of **integrated, accessible** health care services by clinicians who are accountable for addressing **large majority** of personal health care needs, developing **sustained partnership** with patients and practicing in context of **family and community**."*

1. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Reduce-Alcohol-Misuse-ICN907798.pdf

E = Expansion of Primary Care Providers & Workforce

- **ARE** considered primary care settings by CMS
  - Independent clinic
  - Outpatient hospital
  - Physician's office
  - State or local public health clinic

E = Expansion of Primary Care Providers & Workforce

- **NOT** considered primary care settings by CMS:
  - Ambulatory surgical center
  - ER dept.
  - Hospice
  - Independent diagnostic testing facility
  - Inpatient hospital setting
  - Inpatient rehabilitation facility
  - Skilled nursing facility

Source: The Affordable Care Act and Model 4 bundled payments for care improvement, CMS website, 2013

E = Expansion of Primary Care Providers & Workforce

- How PCPs will benefit under ACA:
  - **Medicare bonus payments**
  - ↑ **Medicaid** payments
  - **Debt relief** for medical school tuition
  - **Scholarships** and **loan repayment** if work in medical shortage area
  - $250 million **investment** for PCP training in next 5 years

E = Expansion of Coverage: Medicare and Medicaid

- **Medicare** expansion:
  - Preserves guaranteed Medicare benefits
  - ↑ **FREE** Medicare services:
    - **Preventive care with USPTF rating A or B**
    - **MNT**
    - **Annual wellness visit**

WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH

Provide opportunities for

<u>new</u> and <u>expanded</u> Roles and Responsibilities (R/R's) for diabetes educators and RDs for in all relevant diseases!

A.C.O. is

Accountable **C**are **O**rganization

P.C.M.H. is

Patient **C**entered **M**edical **H**ome

M = Models of New Care Delivery: ACO and PCMH

A.C.O. is

Awesome

Consulting

Opportunities

P.C.M.H. is

Providers **C**ustomizing and

Maximizing **H**ealth

M = Models of New Care Delivery: ACO and PCMH

- ACA's goals for **PCMH's** and **ACO's**:
  - Incent HCPr's to ↑ **quality, efficiency** and ↓ **cost** by:
    - Working as coordinated, integrated **teams**
    - Measuring **quality of care** on continuous basis
    - Bonus payment and ↑ reimbursement based on **performance** measures

DEs and RDs can help meet performance measures!

M = Models of New Care Delivery: ACO and PCMH

- To use **population health management** for **quality improvement** for serious and chronic health conditions resulting in frequent hospital admissions/readmissions
  - Examples:
    - **Diabetes**
    - **Obesity**
    - **Hypertension**

WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH

- **Accountable Care Organizations (ACO)**
  - One legal healthcare entity with shared governance made up of:
    - Providers in group practices
    - Networks of individual practices + ACO professionals
    - Hospitals
    - Clinics
    - LTC facilities
    - Others

M = Models of New Care Delivery: ACO and PCMH

- ACA goals for ACOs:
  - Give **financial incentives** to deliver seamless, high quality care for primarily Medicare beneficiaries via **Medicare Shared Savings Program** (**MSSP**)
    - "Pay for Reporting"
    - "Pay for Performance"

(Telligen, RTI International, 2012)

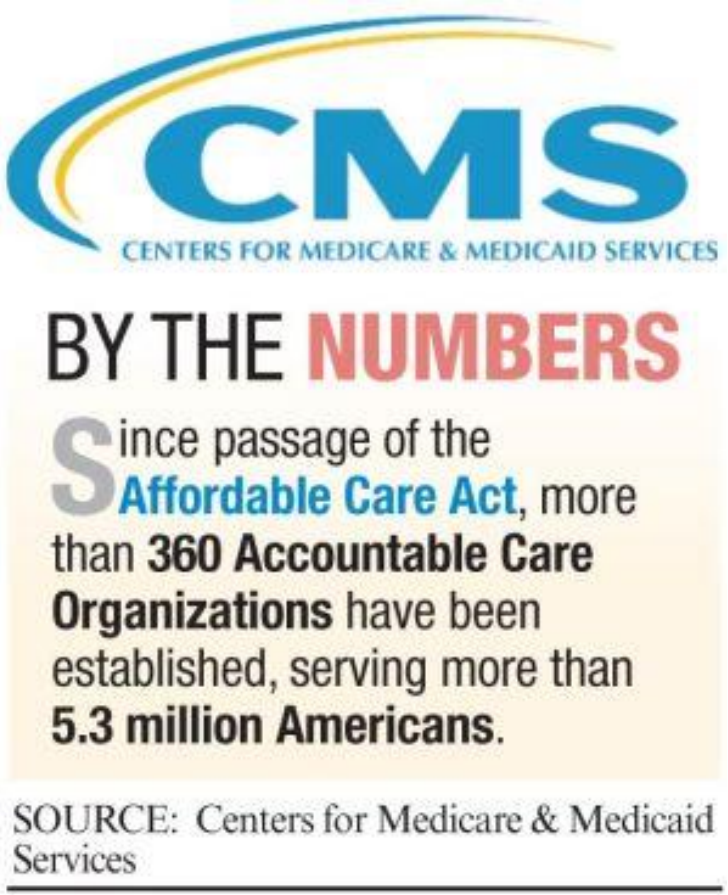
M = Models of New Care Delivery: ACO and PCMH

- Integrate key principles to achieve **ACO accreditation** from **National Committee on Quality Assurance (NCQA):**
  - Evidence-based medicine
  - Patient engagement
  - Care coordination
  - Integration of care
  - Patient centeredness
  - Chronic Care Model

WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH

- **ACO KEY REQUIREMENTS, PER MEDICARE SHARED SAVINGS PROGRAM (MSSP):**



M = Models of New Care Delivery: ACO and PCMH

- **ACO KEY REQUIREMENTS, PER MSSP:**
  - Meet composite scores in 4 domains, based on **quality performance**
    1. Patient/caregiver experience
    2. Care coordination/patient safety
    3. Preventive health and screening
    4. At-risk populations (all or nothing score)

M = Models of New Care Delivery: ACO and PCMH

- **DIABETES quality measures:**
  - **Domain: Patient/Caregiver Experience**
    - Getting timely care, appointments, info
    - How well providers communicate
    - Patient rating of provider
    - Access to specialist
    - **Health promotion and education**
    - **Shared decision making**
    - Health status/functional status

M = Models of New Care Delivery: ACO and PCMH

- **Domain: Preventive Health and Screening**
  - Influenza immunization
  - Pneumococcal vaccination for pts ≥65 y/o
  - **BMI screening + follow-up with documented plan**
  - Tobacco use: screening + cessation intervention
  - Screening for clinical depression + follow-up plan
  - **Screening for high BP + follow-up documented**

WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH

- **Domain: At-Risk Population**
  - **DIABETES** composite score (all or nothing):
    - A1c control (<8%)
    - LDL-C control (<100)
    - High BP control (<140/90)
    - Tobacco non-use
    - Daily aspirin/antiplatelet use

WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH

- Composite score (all or nothing):
  - **Hypertension**
    - Controlling high BP
  - **Ischemic vascular disease**
    - Lipid profile and LDL-C control (<100)
    - Aspirin/antithrombotic use

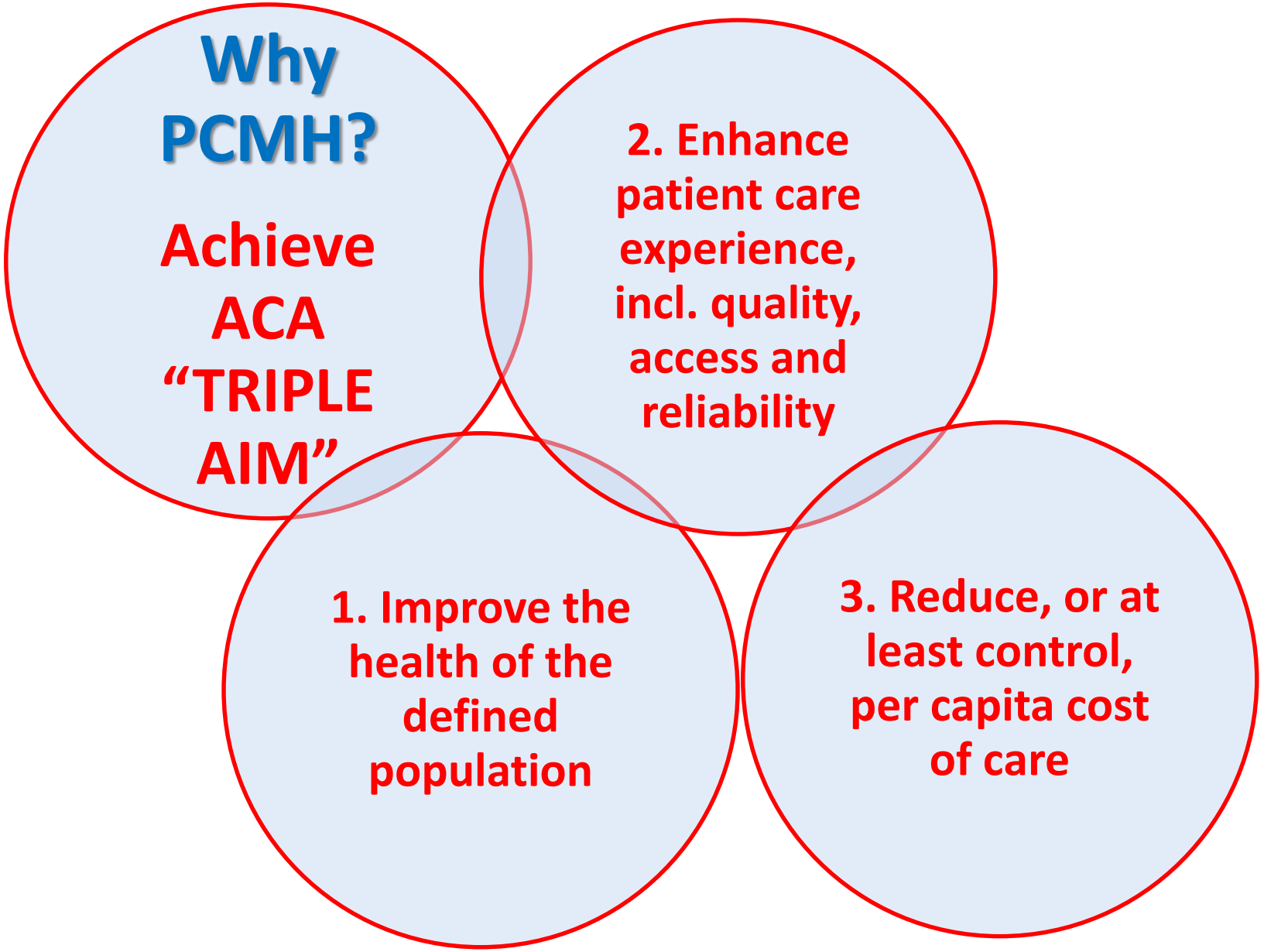
WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH

- **Heart failure**
  - Beta-blocker therapy
- **CAD**
  - Lipid control (<100)
  - ACE inhibitor or ARB therapy

WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH



M = Models of New Care Delivery: ACO and PCMH

PCMH: Joint Principles

- Personal Physician
- Physician Directed Medical Practice
- Whole Person Orientation
- Care is Coordinated
- Care is Integrated
- Quality and Safety are Hallmarks
- Enhanced Access
- Payment Reform

Joint principles of PCMH based on 2007 definition by American Academy of Family Physicians, American College of Physicians, American Academy of Pediatrics, and American Osteopathic Association

M = Models of New Care Delivery: ACO and PCMH

- All **primary care** coordinated out of **central** location
- PCP responsibilities:
  - Managing……regardless of **WHERE** provided:
    - Whole person…….whole health of every patient
    - Chronic Care Model
    - Patient-centered care
    - Patient engagement
    - HIT

WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH

Housed in multiple types of medical entities:

- Primary care clinics
- Community mental health centers
- Adult day care center
- Nursing home, or other long-term care facility
- Anywhere person seeks first-line care

M = Models of New Care Delivery: ACO and PCMH

- Requirements to become **PCMH**:
  - Meeting standards for recognition at 3 levels by *National Committee for Quality Assurance (NCQA)*
    - Level 1 – Basic
    - Level 2 – Intermediate
    - Level 3 – Advanced

NCQA 2014 Standards for PCMH Recognition	Summary of PCMH Requirements
Six standards align with core components of primary care.	
PCMH 1: Patient-Centered Access	Practice provides 24/7 access to team-based care for both routine and urgent needs of patients, families, and caregivers.
PCMH 2: Team-Based Care	Practice provides continuity of care using culturally & linguistically appropriate, team-based approaches.
PCMH 3: Population Health Management	Practice provides evidence-based decision support and proactive care reminders based on complete patient information, health assessment, clinical data.
PCMH 4: Care Management & Support	Practice systematically identifies individual patients & plans, manages & coordinates care, based on need.
PCMH 5: Care Coordination and Care Transitions	Practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.
PCMH 6: Performance Measurement and Quality Improvement	Practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

M = Models of New Care Delivery: ACO and PCMH

- 2014 NCQA **PCMH** standards (core of primary care):
  - **Standard 1: Patient-Centered Access**
    - Practice provides **24/7 access** to team-based care for both routine and urgent needs of patients, families, and caregivers.

WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH

- **Standard 2: Team-Based Care**
  - Practice provides continuity of care using culturally & linguistically appropriate, **team-based** approaches.
  - Care team provides access to evidence-based care, **patient/family education and self-management support**
  - Scope of services available within practice including **behavioral health interventions**

M = Models of New Care Delivery: ACO and PCMH

- **Standard 3**: **Population Health**
  - At least annually the practice proactively identifies populations of patients and reminds them, or their families, caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:
    1. At least 2 different **preventive care services**
    2. At least 2 different immunizations
    3. At least 3 different **chronic** or acute **care services**

M = Models of New Care Delivery: ACO and PCMH

- **Standard 3**: **Population Health**
  - Practice provides **evidence-based decision support** and proactive care reminders based on complete patient information, health assessment, clinical data.
  - To understand health risks and information needs of patients, families, practice collects and regularly updates **comprehensive health assessment** that includes:

M = Models of New Care Delivery: ACO and PCMH

1. Age & gender appropriate immunizations, screenings
2. Family/social/cultural characteristics
3. Communication needs
4. Medical history of patient and family
5. Advance care planning
6. Behaviors affecting health

M = Models of New Care Delivery: ACO and PCMH

- Focus on populations with **chronic diseases** for which **self-management education** and **interventions** proven to:
  - **Improve outcomes**
  - **Reduce disease complications and exacerbation**

M = Models of New Care Delivery: ACO and PCMH

- **Standard 4: Care Management and Support**
  - Practice systematically identifies individual patients & plans, manages & coordinates care, based on need.
  - Use evidence-based **behavior modification strategies** and tools.
  - Element 4B: **Care Planning and Self-Care Support**
    - Care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an **individual care plan** that includes following features for **>75% of patients** identified in Element A:

M = Models of New Care Delivery: ACO and PCMH

1. **Incorporates patient preferences and functional/lifestyle goals**
2. **Identifies treatment goals**
3. **Assesses and addresses potential barriers to meeting goals**
4. **Includes a self-management plan**
5. **Is provided in writing to the patient/family/caregiver**

WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH

- **Standard 5: Care Coordination and Care Transitions**
  - Practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.
- **Standard 6: Performance Measurement and Quality Improvement**
  - Practice uses performance data to identify opportunities for improvement and **acts to improve clinical quality, efficiency and patient experience.**

WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH

- NCQA's Clinical Recognition Programs
  - **Diabetes Recognition Program (DRP)**
  - **Heart/Stroke Recognition Program (HSRP)**
  - Back Pain Recognition Program (BPRP)

WHAT ARE YOUR OPPORTUNITIES?

M = Models of New Care Delivery: ACO and PCMH

- **Diabetes Recognition Program (DRP)**
  - Recognizes clinicians who use **evidence-based** measures and provide excellent care to their PWDs
  - Eligible clinicians submit data on 11 measures from 25 PWDs' charts that include:
    - **A1c control**
    - **BP control**
    - **LDL control**
    - Eye exams
    - Nephropathy assessment
    - Smoking/tobacco use and cessation advice, treatment

WHAT ARE YOUR OPPORTUNITIES?

I = Investments and Research in HIT, Quality, Efficiency and Population Health

- Invest in *National Strategy for Quality Improvement in Health Care*: NSQI's **6 priorities:**

1. Make health care **safer**
2. Promote pt + family **engagement as healthcare partners**
3. Promote effective **coordination of care**
4. Promote most effective **prevention** practices (ex, CVD)
5. Integrate **communities** into ongoing health care
6. Make quality care more affordable via **new health care delivery** and **reimbursement models**

Providers and programs will strive to meet priorities.

WHAT ARE YOUR OPPORTUNITIES?

I = Investments and Research in HIT, Quality, Efficiency and Population Health

- Invest in *Health Information Technology for Economic and Clinical Health (HITECH) Act*
  - To improve health care delivery via huge investment in HIT
  - Achieved via support, coordination, connectivity and promotion of "**meaningful use**" **of EHR**

WHAT ARE YOUR CHALLENGES?

I = Investments and Research in HIT, Quality, Efficiency and Population Health

- Invest in EHR "meaningful use" incentives
  - Medicare: **reimbursement reduction** if non-compliant by **2015**
  - Medicaid: **NO** reimbursement reduction if non-compliant
- Participation:
  - Providers: can only participate with 1 incentive
  - Hospitals: may participate in both incentives

WHAT ARE YOUR CHALLENGES?

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- Fee-for-Service (FFS):
  - Creates misaligned incentives:
    - Incentivizes more services & duplication of
    - Less care coordination
    - Less incentive for preventative care
    - High quality care paid same as low quality

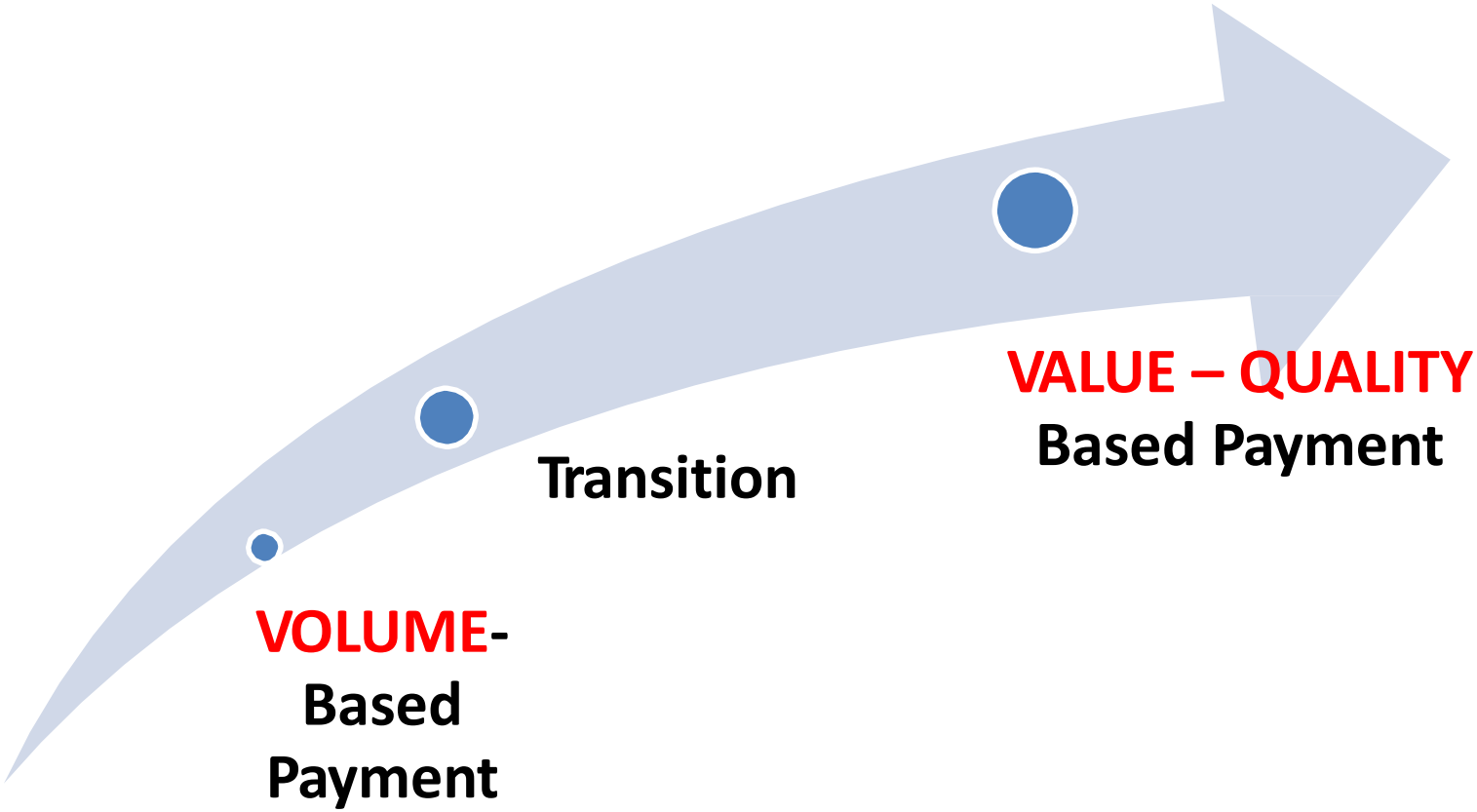
FFS is going out!
….just like: →

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- ACA attempts to drive higher quality and less costly care through a mixture of:
  - Incentives/rewards/bonuses, and
  - Penalties
- Reimbursement reform models increasingly:
  - Tied to **value** and **quality** and
  - Shifting away from fragmented, **volume**-driven payments

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- We‘re transitioning from **VOLUME**-based payments to **VALUE** – **QUALITY** based payment:



E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- Benefits of **VALUE – QUALITY** based payments:
  - Removes incentives for duplication/increased services
  - Attempts to balance quality and cost
  - Rewards outcomes
  - Rewards removing fragmentation and conflicting incentives
  - Attempts to align provider, payer and patient incentives

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

New Reimbursement Reform Models, per the ACA:

- Pay-for-Performance
- Pay-for-Quality
- Pay-for-Value (Medicare)
- Pay-for-Reporting

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- Shared Savings
- Bundled Payments
- Bonus and/or Increased Payments for:
  - Meeting Quality Targets or
  - Progress toward
- Global Payments
- Reduced Payments for:
  - Not using EMR

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- Matching Payments
- Adjusted Payments
- Tax Reduction Incentives
- Reimbursement for:
  - Care Coordination
  - Transitional Care
  - Telehealth
- Federal Funding for Incremental Costs
- Small Business Tax Credits

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- Medicare's **quality** and **value-based** payment programs:
  - **Hospital Readmissions Reduction Program**
    - Medicare is↓ payments to acute care hospitals with high readmissions with 30 days of discharge
    - Readmits may be due to hospital stay factors such as:
      - Complications from treatments
      - Inadequate or poorer quality:
        - Treatment
        - Care coordination
        - Follow up care in community

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- **Hospital Value-Based Purchasing (VBP) Program**
  - Medicare's pay-for-performance payment system for inpatient stays in ~ 3000 hospitals
  - Portion of hospital payments based on either:
    - How well hospital performed on each quality measure compared to all hospitals, or
    - How much hospital improved own performance on each measure compared to its performance during prior baseline period
  - Designed to promote better clinical outcomes for inpts and improve their experience of care

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- Reduce silos of care
- Get physicians involved and working **collaboratively** with hospital, clinicians, staff and other physicians

– Incentives must be:

- Measurable, controllable, realistic, time-boxed with specified frequency of measurement and payout
- Show improvement in quality and/or efficiency

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- **Hospital-Acquired Condition (HAC) Reduction Program**
  - Medicare is ↓ payments (reduced to 99%) of acute care hospitals paid under hospital inpatient prospective payment system (IPPS) that rank in worst performing quartile for HACs among these hospitals
  - Designed to encourage these hospitals to ↓ HACs

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- **Medicare Shared Savings Program (MSSP) in ACOs**
  - Providers and suppliers work together to manage and coordinate care for fee-for-service beneficiaries
  - ACOs agree to be accountable for the quality, cost and overall care of beneficiaries "assigned" to it
  - MSSP intended to:
    - Promote accountability for care of beneficiaries
    - Require coordinated care for all services provided under Medicare FFS
    - Encourage investment in infrastructure and redesigned care processes

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- **Value-based contracting with provider**
  - Contract with provider containing financial rewards (bonus pay) in order to:
    - **↑ performance to**
    - **↑ quality and ↑ health outcomes, and thus**
    - **↓ costs**
      - **NOT** rewarded for more and more services billed to payers in **fee-for-service** payment systems

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- 1st model of **value-based provider contract:**
  - *Portion* of provider's total fee-for-service payment tied to provider's performance on **cost-efficiency** and **quality performance measures** ....can be:
    - Bonus payment OR
    - Part of payment withheld

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- 2nd model of **value-based provider contract:**
  - Clinical integration payments paid to providers who engage in **practice transformation**
    - Are adopting new ***technologies (EHR) and processes*** that change how care is delivered….. with goal of:
      - ❖ **↑ performance to**
      - ❖ **↑ quality and ↑ health outcomes, and thus**
      - ❖ **↓ costs**

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- Examples of new care delivery models:
  - Patient-centered medical home and ACOs
- Example of clinical integration payment types:
  - **Premium base rates** — Increased fee-for-service rates based on expected performance
  - **Performance incentives** — Incentive payments made for performance improvement initiatives
  - **Shared savings** — Savings shared based on a reduction in cost of care

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- Medicare Value-Based Modifier (M-VBM)
  - Adjustment made by to payments on claim for items/services paid under Physician Fee Schedule (PFS)
  - Adjusted payments based on **quality of care** furnished compared to **cost of care** during specific performance period (calendar year)
  - Providers affected: **physicians and eligible non-physician providers**
    - **Applies to RDs as paid for MNT under PFS**

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- M-VBM now aligned with reporting requirements under **Physician Quality Reporting System (PQRS)**
  - For RDs to **avoid 2016** payment ↓, RD must
    - ❖ Satisfactorily report and earn 2014 PQRS payment ↑

      OR

    - ❖ Report ≥3 PQRS measures covering 1 domain in a National Quality Strategy (NQS) for ≥50% of their Medicare Part B pts satisfactorily

E = Economic Incentives and Payment Models to Improve Quality of Care and Efficiency

- M-VBM now aligned with reporting requirements under **Physician Quality Reporting System (PQRS)**
- 2015: Medicare applies VBM payment to PFS for physician groups of ≥100
- 2013 = performance period for VBM applied in 2015:
  - To avoid 1.0% less VBM payment adjustment in 2015, physician groups of ≥100 were required to:
    - ❖ Report ≥1 measure in PQRS Group Practice Reporting Option in 2013 OR
    - ❖ Elect CMS-calculated administrative claims option as group in 2013

Changing Roles and Responsibilities (R/R's)

of DE and RD

Changing Roles and Responsibilities (R/R's) of DE and RD

Reasons *why* DE/RD R/R's will need to change…*and how:*

1. **Provider payment models are changing**
   - Will receive **incentive bonus payments, increased reimbursement, Medicare Shared Savings Plan, bundled payments, etc…..** all based on ability to:
     - ↑ quality and ↓ costs (in quantifiable, reportable way)
     - Coordinate patient care efficiently and effectively

- ***New R/R's:***
  - *Will need to prove to providers that their skills can help their practices receive incremental revenue*
  - *Business and financial management know-how critical*

Changing Roles and Responsibilities (R/R's) of DE and RD

2. **Healthcare delivery models are changing: PCMH/ACO**
   - Models must meet **NCQA's standards** to be recognized as such; many standards related to DE's and RD's:
     - **Educating pts on self-management of chronic diseases**
     - Integrating new patient behaviors to improve health
     - Coordinating care with 'whole person' orientation
     - Fostering patient-centered care and patient engagement
     - Emphasizing patient feedback

Changing Roles and Responsibilities (R/R's) of DE and RD

- Aligning standards with processes that ↑ quality, ↓ waste
- Using team-based care with trained staff
- Identifying and managing health of patient populations
- Tracking + reporting of clinical performance measures of individual care
- Using clinical performance measure results to ↑quality

DE/RD will need to show providers how their skills can help them receive this incremental revenue!

Changing Roles and Responsibilities (R/R's) of DE and RD

- ***New R/R's:***
  - *Will need to align skills and competencies with quality standards that ACO/PCMH must meet, and position themselves for R/R's in:*
    - *Business and resource management*
    - *Practice and system support*
    - *Case management*
    - *CQI*
    - *EMR, HIT, informatics, analytics*
    - *Health system navigation*
    - *Leadership*

Changing Roles and Responsibilities (R/R's) of DE and RD

- *Organizational development*
- *Patient engagement*
- *Patient self-management education all chronic diseases*
- *Community integration*
- *Motivational interviewing*
- *Screenings for early identification + prevention*
- *Self-management education for prevention*
- *Outcomes monitoring, management and analysis*

– Aetna, Cigna stated **care coordinators** pivotal to success

Changing Roles and Responsibilities (R/R's) of DE and RD

3. **Big goal of ACA is to increase:**
   - **Primary care** furnished in:
     - PCP offices….PCMH's…..ACO's
   - Primary care emphasis on:
     - Treating "**whole person**"
     - Successfully **navigating** patient through healthcare system to receive evidence-based care
   - Primary **prevention**
   - Primary care **chronic disease management**

Changing Roles and Responsibilities (R/R's) of DE and RD

- ***New R/R's:***
  - *To achieve this ACA goal, **new roles** need to be filled inside PCP's offices, PCMH's, ACO's*
  - *New roles will mean **new responsibilities***
  - *To fill new roles, DE's/RD's will need to **enhance** their skills and competencies*
- ***New challenges:***
  - ***Other HCPs** will be competing for these R/R's!*

Changing Roles and Responsibilities (R/R's) of DE and RD

Let's Review:

New roles that healthcare professionals will need to fill….

New responsibilities that come with new roles.

Changing Roles and Responsibilities (R/R's) of DE and RD

- ***Certified Health Education Specialist (CHES)***
- ***Master Certified Health Education Specialist (MCHES)***
  - Credentialed by *National Commission on Health Education Credentialing, Inc*. (http://nchec.cyzap.net)
  - **MCHES** eligible to take **CDE exam** as of 1-1-14
    - Per NCBDE, **MCHES** credential closely aligned with competencies of CDE
  - Credential proves possession of knowledge + skills to strengthen physician-directed team to improve patient health outcomes

Changing Roles and Responsibilities (R/R's) of DE and RD

– ***New R/R's:***

- Coordinate and integrate care, using holistic approach to prevention and disease management
- Provide self-management support using proven coaching skills
- Use evidenced-based strategies for health improvement
- Identify structural and goal barriers to behavior △

Changing Roles and Responsibilities (R/R's) of DE and RD

- Design culturally competent and patient-centered programs to improve outcomes, which includes:
  - Goal setting, action planning, cognitive behavioral techniques, tailored communication
  - Motivational interviewing
- Partner with patients in **primary prevention** and **chronic disease management**
- Serve as bridge to other healthcare providers, and community resources to individuals + groups to help patients:

Changing Roles and Responsibilities (R/R's) of DE and RD

- Adopt, maintain healthy behaviors
- Build social and physical environments with their families that support pt's behavior change
- **Navigate** health care system

- Provide **health promotion/prevention** programs
- Aid medical entity with **practice/system support**
- **Coordinate care** with other clinicians
- **Integrate** and connect pt to community resources

Changing Roles and Responsibilities (R/R's) of DE and RD

- ***Care Coordinator*** ("new" social worker)
  - Highly trained in:
    - Care coordination…communication…collaboration
  - ACA elevated R/R's of **Care Coordinators**:
    - Serve wide variety of pts with special needs
      - Esp. with **chronic, complex conditions** who receive care in **multiple settings** from **multiple providers**
    - Preserve scarce and costly resources
    - Include **case management** and **care management**
    - Involve direct clinical interventions delivered to pts

Changing Roles and Responsibilities (R/R's) of DE and RD

- ACOs/PCMHs may require discipline types to have ***"Certified Case Manager"*** credential
  - LCSW
  - RN
  - OT
  - RD
  - Mental health counselor

WHAT ARE YOUR OPPORTUNITIES?

Changing Roles and Responsibilities (R/R's) of DE and RD

- ***Patient Navigator***
  - "Navigate" pt through all layers of now fragmented, inefficient healthcare system and get timely care
  - Identify pt barriers to healthcare
  - Connect pt to resources needed: financial assistance, counseling, language translation, transportation, etc.
  - Types: RN, RD, LCSW, CHES…*or those with NO health degree*

WHAT ARE YOUR OPPORTUNITIES?

Changing Roles and Responsibilities (R/R's) of DE and RD

- ***Case Manager (CM)***
  - Elevated career path for RNs, RDs and others
  - Integral part of success of health care reform
  - Predictions:
    - ACA mandates will utilize CM's in more settings
    - ACOs will sorely need CMs with advanced practice nurse skills to fill roles of:
      - Leadership
      - Resource management
      - Analytical, informatics, organizational development

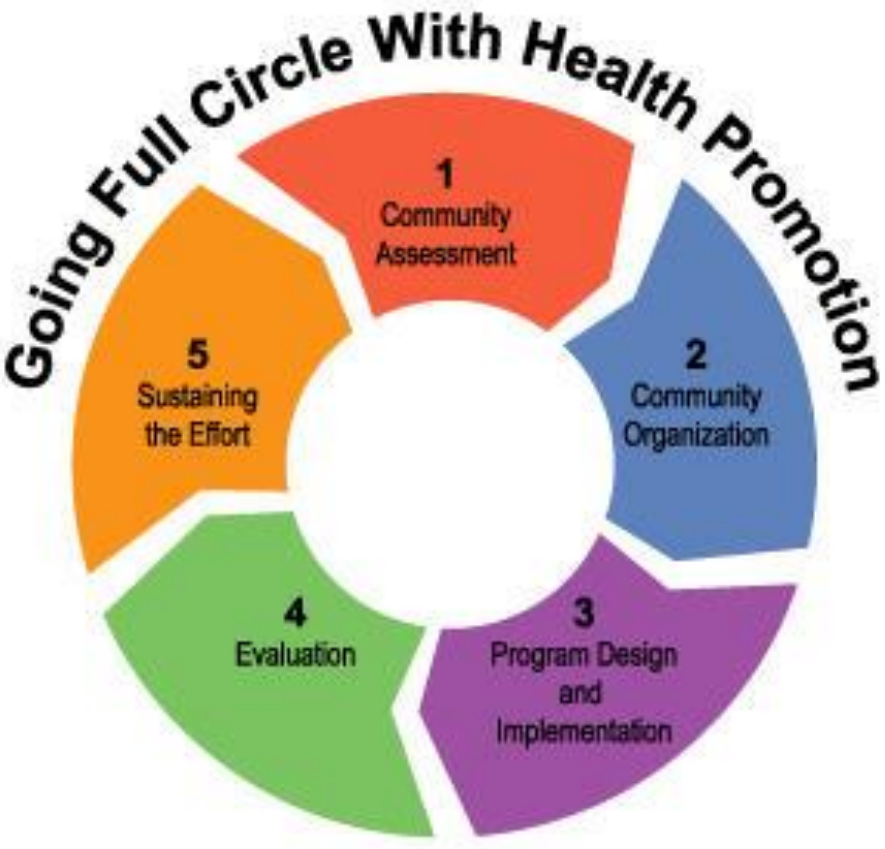
Changing Roles and Responsibilities (R/R's) of DE and RD

4. **Goal of ACA is to increase prevention efforts and health promotion (HP) in:**

   – Primary care practices

   – Community

   – Work sites



Changing Roles and Responsibilities (R/R's) of DE and RD

- ***New R/R's:***
  - *DE's/RD's to redefine role as **health promotion specialist***
  - *HP typically requires **health risk assessment, screenings***
  - *HP addresses key prerequisites of health:*
    - *Income, housing, food security, employment*
    - *Safety (seat belt use, food safety, etc.)*
    - *Medical risk factors (obesity, HTN, lipids, etc.)*
    - *Lifestyle risk factors (diet, stress, exercise, etc.)*
    - *Quality working conditions*

1. World Health Organization's (WHO) 2005 Bangkok Charter for Health Promotion in a Globalized World

Changing Roles and Responsibilities (R/R's) of DE and RD

- ***Health Promotion Specialist***
  - Conducts health risk assessments
  - Provides education for health behavior change
  - Develops and/or help passes health legislation
  - Creates health communication campaigns
  - Organizes community members and partner organizations to implement health programs

Changing Roles and Responsibilities (R/R's) of DE and RD

- ***Worksite Wellness Manager***
  - Practice art and science of building measurable, results-oriented employee wellness program
  - Links program to company's benefit plan design, including healthcare insurance

Changing Roles and Responsibilities (R/R's) of DE and RD

5. **Goal of ACA: ↑ number of individuals with healthcare insurance and ↑ health of U.S.**

   – Health plan "**exchanges**" will ↑ number of insured

   – Exchanges must include 10 **essential health benefits**

   - 2 of EHB's affect DE and RD most:
     - **Preventive Care** and **Ambulatory Care**

WHAT ARE YOUR OPPORTUNITIES?

Changing Roles and Responsibilities (R/R's) of DE and RD

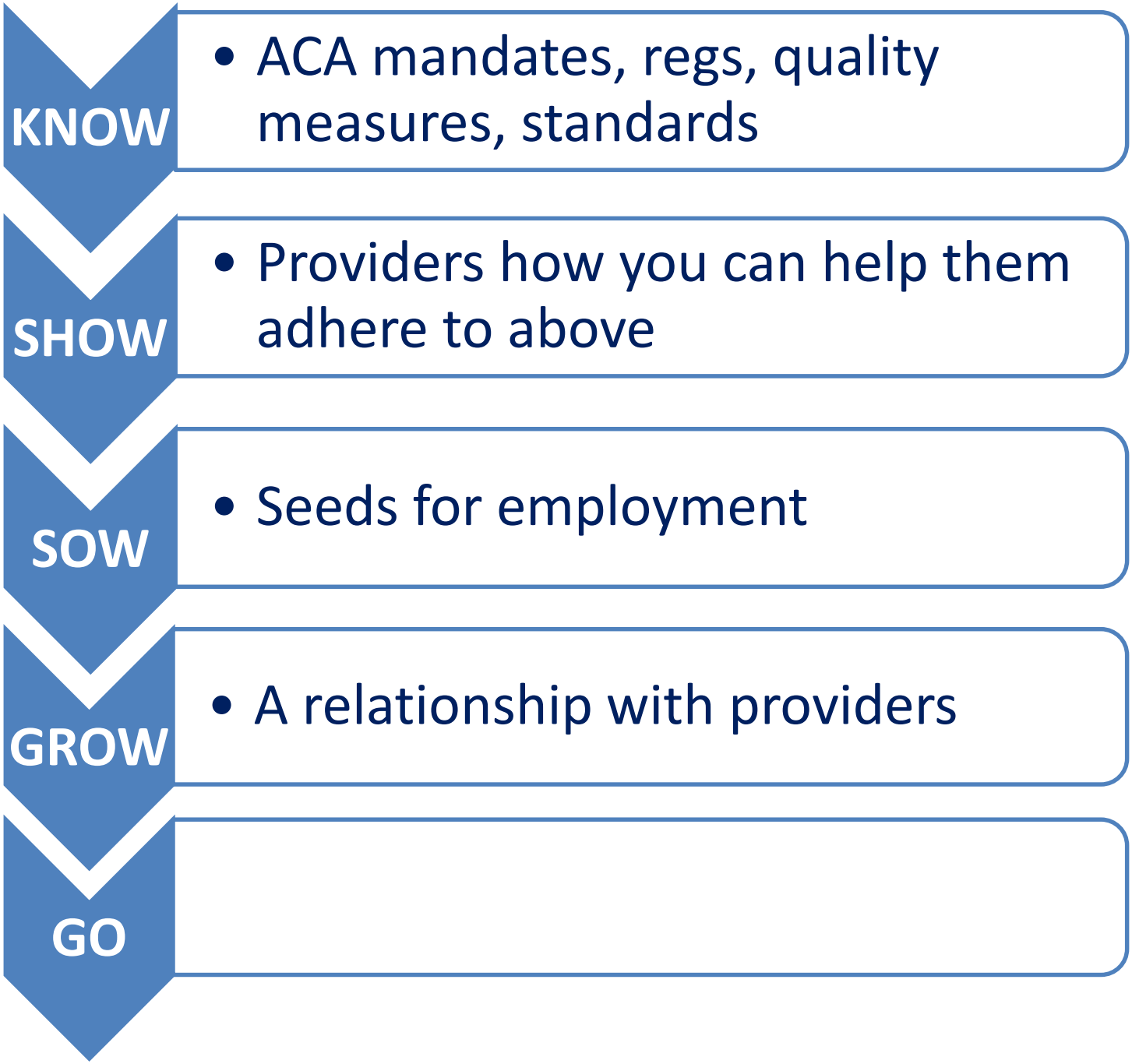
- ***New R/R's:***
  - *Have good understanding of 4 "metal" levels of health plan exchanges in order to help patients navigate "shopping" for and select most appropriate*
  - *Know exactly what **free preventive services** are in order to recommend, facilitate and furnish!*

CONDENSED Strategies

for Diabetes Educators and RD's

to Assume

New Roles and Responsibilities


KNOW
• ACA mandates, regs, quality measures, standards
SHOW
• Providers how you can help them adhere to above
SOW
• Seeds for employment
GROW
• A relationship with providers
GO

Full Strategies for Educators and RD's to Assume New Roles and Responsibilities

D	**D**evelop skills in health risk assessment, health promotion, prevention, screenings, and all chronic disease interventions
S	**S**ync up skills and services with criteria for new payment models, ACO/PCMH recognition, health plan exchanges, essential health benefits exchanges must cover, free preventive services
M	**M**otivate, don't dictate • MI leads to pt engagement, positive outcomes, pay-for-performance…and meets standard for ACO/PCMH recognition
E	**E**xpand your roles and responsibilities (R/R's) • Certified Health Education Specialist, Care Coordinator, Case Manager, Patient Navigator, Health Promotion Specialist

N	**N**ever miss opportunity to advocate for licensure and our bills
U	**U**nderstand importance and principles of marketing: you, your skills, credentials, knowledge of ACA mandates r/t role, etc.
T	**T**arget ACOs/PCMHs for assuming new roles with professional DSMES/MNT business plan
R	**R**ecognize growth of employee wellness programs and role in
I	**I**ncrease skills in HIT, EMRs, especially in population management
T	**T**eam Up! Patient-centered multi-disciplinary teams replacing individuals working in silos
I	**I**mplement shared medical appointments
O	**O**btain enhanced skills in quality improvement, outcomes measurement and management (key to pay-for-performance)
N	**N**egotiate independent practitioner arrangement in new health care delivery models (ACO/PCMH) if there is no employee option

What Now? You Need a DSME/MNT Business Plan!

IF you want your DSMES/MNT Program to be successfully integrated into ANY practice, including PCMH's and ACO's, you must

THINK like a business and

ACT like a business!

Your DSMES/MNT PROGRAM is a business!

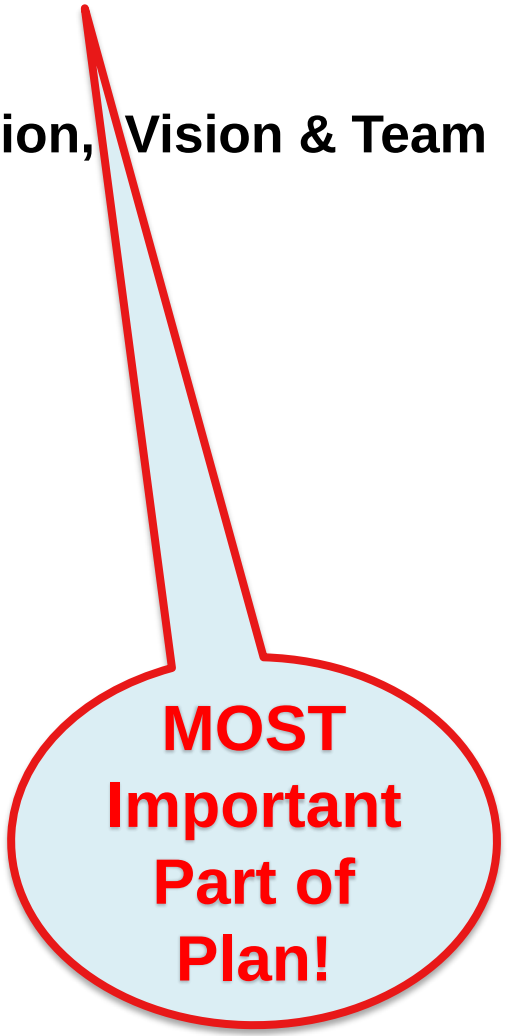
It thus requires professional BUSINESS PLAN!

What Now? You Need a DSME/MNT Business Plan!

- About **DSMES/MNT Business Plan**
  - Presented to employer: hospital, clinic, physician group, PCMH administrators, ACO governing body, etc.
  - Printed professionally and bound with cover
  - KEY requirement to:
    - "Making the case" for DSMES/MNT Program
    - Aligning program with PCMH's/ACO's:
      - Standards for NCQA recognition
      - Goals
    - Proving you are business professional with advanced:
      - DSMES/MNT **and** business management skills

12 Major Components of DSMES/MNT Program Business Plan

1. Executive Summary (Written Last But Presented First)
   - Includes Statement of Purpose
2. Description of Your Company/Legal Entity + Major Accomplishments
3. Business Concept, Business Strategy and Benefits and Value of DSMES/MNT Program to PCMH/ACO
   a. Concept: Overview of DSMES/MNT Program Mission, Vision & Team
   b. Strategy: How Success is Defined and Measured
4. DSMES/MNT Program Structure/Design
5. Target Markets of DSMES/MNT Program
6. Market Analysis and Competition Analysis
7. Marketing Plan: 7 Ps
8. Operations/Process Plan
9. Financial Plan and Projections
10. Continuous Quality Improvement Plan
11. Clinical Plan
12. References and Exhibits



Why You Need to Write a Business Plan: H.E.A.R.T.

H = **H**andcraft your detailed roadmap to achieve goals

E = **E**xplore all possibilities

= **E**nsure careful, educated decision making

= **E**valuate feasibility of your idea

= **E**arn your credibility

= **E**stablish benchmarks in business cycle

A = **A**nswer 1000 questions on planning your business

= **A**ttract investors

= **A**ttract a future employers

= **A**cquire approval and required resources

Why You Need to Write a Business Plan: H.E.A.R.T.

= **A**ssure you will identify and help your customers achieve their:

1. Goals
2. Unmet/poorly met needs
3. Unmet/poorly met needs in manner that:
    - Suits customers' preferences
    - Suits customers' preferences better than competition
        - 3 biggest keys to get customers to buy what you're selling

R = **R**educe resource expenditures (human, $, energy)

T = **T**ackle bugs, barriers, kinks to stop from occurring

Mary Ann has a very detailed presentation titled:

How to Write a Successful and Effective DSME/MNT Business Plan

And Now Let's Focus on YOU!

10 Step ACA Action Plan

To Align You and Your Career with

New Roles and Responsibilities (R/R's)

the ACA Requires

Acquire	Knowledge of: relevant ACA laws, language and new care delivery models (ACO, PCMH, schools, demo projects)
Assess	Type of **new** roles and responsibilities (R/R's) required in **new** care delivery models, OR **new** R/R's required in your existing job to help you implement ACA laws
Ascertain	Skills and competencies required for **new** R/R's
Assess	Whether you have the skills and competencies
Analyze	Competition to see who has already assumed **new** R/R's. Threats and opportunities. Strengths and weaknesses.
Arrive	At decision: *"Do I want to assume a new role?"* **If YES:**
Attain	New skills and competencies required for new **role**
Adapt	Resume/CV to these **new** R/R's; use ACA language!
Apply	For job with **new** R/R's OR **Adapt** existing job to R/R's
Acquire	Continuing knowledge of ACA, as things WILL change!


it always
seems
IMPOSSIBLE
until
it is
DONE!

ACA Will Change! Keep Learning at: www.healthcare.gov

I'm
so sleepy
after
all that info!

LEARNING ABOUT ACA AND YOUR NEW R/R'S!

ALL IT TAKES IS A LITTLE DESIRE AND STRENGTH ON YOUR PART!

YOUR PATIENTS, PROVIDERS & STAFF WILL LOVE YOU FOR IT!

DO YOUR HOMEWORK, BE PREPARED AND TAKE THE **PLUNGE**!

OTHERWISE, YOU'RE GOING TO WAKE UP ONE MORNING, AND REALIZE YOU'VE MADE A SIGNIFICANT BOO-BOO!

OR YOU MAY FIND YOURSELF UP A CREEK WITHOUT A PADDLE!

EFFECT OF INFORMATION OVERLOAD!

Never regret

growing older…

it is a privilege

denied to many.


QUESTIONS?

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The information does not necessarily reflect opinions, policies and/or official positions of the Center for Medicare and Medicaid Services, private healthcare insurance companies, commercial entities or professional associations. Information contained herein is subject to change by these and other organizations at any moment, and is subject to interpretation by its legal representatives, end users and recipients. Readers should seek professional counsel for legal, medical, ethical and business concerns. The information is not a replacement for the Academy of Nutrition and Dietetics' Practice Guidelines and professional resources, American Diabetes Association's Standards of Medical Care in Diabetes or American Association of Diabetes Educators professional resources. As always, the reader's clinical judgment and expertise must be applied to any and all information in this document.

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Resources by Mary Ann Hodorowicz

Turn Key Materials for AADE DSME Program Accreditation

- DSME Program Policy & Procedure Manual Consistent with NSDSME (72 pages)
- Medicare, Medicaid and Private Payer Reimbursement
- Electronic and Copy-Ready/Modifiable Forms & Handouts
- Fun 3D Teaching Aids for AADE7 Self-Care Topics
- Complete Business Plan

3-D DSME/T and Diabetes MNT Teaching Aids 'How-To-Make' Kit

- Kit of 24 monographs describing how to make Mary Ann's separate 3-D teaching aids plus fun teaching points, evidence-based guidelines and references

Money Matters in MNT and DSMT: Increasing Reimbursement Success in All Practice Settings, The Complete Guide ©, 5th. Edition, 2015

Establishing a Successful MNT Clinic in Any Practice Setting©

EZ Forms for the Busy RD©: 107 total, on CD-r; Modifiable; MS Word

- Package A: Diabetes and Hyperlipidemia MNT Intervention Forms, 18 Forms
- Package B: Diabetes and Hyperlipidemia MNT Chart Audit Worksheets: 5 Forms
- Package C: MNT Surveys, Referrals, Flyer, Screening, Intake, Analysis and Other Business/Office and Record Keeping Forms: 84 Forms